Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225–3625
Washington, DC 20515–6348
http://waysandmeans.house.gov

July 28, 2005

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator McClellan:

We are deeply troubled by the growing segmentation of the health care delivery system in our country, and the continued disparities experienced by people of color. At present, at least two-tiers seem to exist: one for people who are healthy or have relatively good insurance and another for people who have inadequate or no health insurance. This segmentation is magnified for ethnic and racial minorities, where data have shown that access and outcomes differences remain even when insurance status is controlled for.

Recent evidence from the GAO, the Medicare Payment Advisory Commission (MedPAC) and the Center for Medicare and Medicaid Services (CMS) suggests that physician-owned specialty hospitals could be contributing to some of this segmentation by engaging in favorable patient selection. For example, MedPAC's 2005 report on the topic showed that physician-owned specialty hospitals tend to treat patients who are less sick – and therefore more profitable – than those treated at full-service community hospitals. The report also showed that these facilities tend to treat a lower share of Medicaid patients than the community hospitals in the same market.

Even more alarming, new information from MedPAC suggests possible discrimination based on ethnic or racial factors may be prevalent in the physician-owned specialty hospital industry. The May 2005analysis, conducted at the request of the Senate Finance Committee, found that physician-owned cardiac specialty hospitals had a significantly smaller share of black Medicare patients relative to community hospitals in the same market. Among the hospitals that were included in the analysis, the racial breakdown of Medicare discharges from the specialty hospitals in 2002 were 92.1 % white, 3.6 % black, 1.7 % Hispanic and 2.6 % other. In contrast, the racial breakdown of Medicare discharges from the full service community hospitals in 2002 were 85.2 % white, 9.6 % black, 2.2 % Hispanic and 3.1 % other. This analysis shows that the

percentage of black Medicare patients discharged from full-service hospitals in the sample was nearly three times the percentage seen in the study's physician-owned heart hospitals in the same market.

At a recent hearing on specialty hospitals in the Senate Homeland Security and Governmental Affairs Committee, MedPAC was not able to explain this pattern. According to Mark Miller, Executive Director of MedPAC:

> "I'm not sure I can shed light, and just to clarify a couple things, it's very clear from our analysis, when we look at discharge data, that specialty hospitals are serving significantly fewer Medicaid patients. There's lots of reasons that that could be the case. We don't particularly have a definitive analysis that says that. The location of the hospital -- it could be the contracts that they're involved in. It could be any number of things. On the issue of the mix of the patients by race, I think my response is the same. Exactly what is generating that kind of pattern is not something that we looked directly at. You can observe it in the data. It is definitely there, as you said. But what generates that actual result, I don't think I could say."

Given that the GAO (GAO-03-862R, July 2003), Institute of Medicine and even HHS have consistently found that disparities persist in terms of access and quality of care for racial and ethnic minority groups, we are writing to ask that CMS fully explore this issue and respond in writing with your findings and a plan to address these issues prior to lifting the current certification moratorium on physician-owned specialty hospitals. In an effort to better understand the situation, we ask that your analysis include at least the following items:

- Examination of self-referral patterns to physician-owned specialty hospitals in an effort to better understand why minority Medicare patients are less likely to be admitted or referred to these facilities;
- Additional analyses to examine Medicare discharges by race for surgical and orthopedic physician-owned specialty hospitals;
- Examination of discharge data by race from physician-owned specialty hospitals for patients with other public or private insurance or who are uninsured;
- A determination of whether minority access to physician-owned specialty hospitals differed based on Medicare fee-for-service versus Medicare managed care;
- Recommendations on how best to address the differential access.

It is unfortunate that minority access issues were not a metric explored in your June 2005 report to Congress on specialty hospitals. Nevertheless, it is our hope and expectation that now that you are aware of this data, CMS will maintain the current administrative moratorium for physician-owned specialty hospitals until this analysis is complete and these questions are satisfactorily answered and resolved.

As we celebrate Medicare's 40th anniversary, one of its most important achievements, in concert with the Civil Rights Act, was its contribution toward desegregation of America's health care system. We are confident you share both our concerns and desire to protect access for all Medicare beneficiaries. If you have any questions or need additional information, please contact Cybele Bjorklund on the Democratic staff of the Committee on Ways and Means at 225-4021. We look forward to your response.

Sincerely,

Charles B. Rangel
Ranking Member

John Lewis
Ranking Member
Oversight Subcommittee

Pete Stark
Ranking Member
Health Subcommittee

Enclosure

Medicare admissions by type of hospital and race

As you requested in your letter dated May 5, 2005, we examined the extent to which physician-owned specialty hospitals and several groups of community hospitals serve Medicare patients in different race categories. This analysis is based on the same data we used in our recent mandated report to the Congress on physician-owned specialty hospitals. This memo summarizes our methods, data, and findings.

Methods and data

To carry out this analysis, we estimated Medicare patient shares by race category for 11 physician-owned heart hospitals and 79 community hospitals that are located in the same markets, and compete with, the physician-owned heart hospitals. Competitor community hospitals are defined as general acute care hospitals that are located in the same hospital referral regions as the physician-owned heart hospitals and treated at least 10 Medicare patients in common heart-procedure diagnosis related groups (DRGs) in 2002.[1] As requested, we also made separate estimates for the competing community hospitals in three ownership groups:

- 52 not-for-profit hospitals,
- 20 proprietary hospitals, and
- 7 government-owned hospitals.

To ensure comparability between hospital groups, we limited the analysis in two ways. First, we examined only heart specialty hospitals because physician-owned orthopedic and surgical hospitals had too few discharges to draw conclusions with confidence about their patient shares by race category. Second, we compared heart specialty hospitals only with competitor hospitals serving the same markets to avoid the potential bias of comparing populations with different underlying race shares.

For each hospital group, we estimated hospitals' shares of Medicare inpatient discharges among four race categories, as defined in the MedPAR claims files:

- white,
- black,
- Hispanic, and
- other (which includes Asian American, native American, and all other patients, including those with unknown race).

We calculated overall estimates for each hospital group based on all Medicare hospital inpatient claims for the group in the MedPAR file for fiscal year 2002. We also examined the distribution of patient shares by race category among the hospitals within each hospital group to determine if the hospitals in each group exhibited similar or different patterns.

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[1]Hospital referral regions are defined in the Dartmouth Atlas of Health Care based on referral patterns for coronary artery bypass graft surgery.

Findings

Based on 2002 data, physician-owned heart hospitals appear to treat smaller shares of black patients, on average, while their shares of Hispanic and other patients are similar to those in not-for-profit or proprietary community hospitals (Table 1). In contrast, government-owned competitor hospitals have substantially higher shares of black, Hispanic, and other patients than any other hospital group.

Among the hospitals within each group, patient shares for black Medicare patients appear to vary widely and some hospitals in every group treat low shares of black patients (Chart 1). For example, black patients account for less than 2 percent of all Medicare patients in one-quarter of all not-for-profit hospitals. At the high end, nearly 60 percent of government-owned competitor hospitals have more than a 9 percent share of black Medicare patients.

Finally, it is important to bear in mind that the race classifications on the source data may not be precise, for example, Hispanic beneficiaries may classify themselves as black, white, or Hispanic.

Table 1. Specialty heart hospitals and their local competitors treat different mixes of Medicare patients
Average shares of Medicare discharges by race for heart specialty hospitals and competitors in 2002

Hospital group	Number of hospitals	Discharges in group	Share of discharges by race			
			White	Black	Hispanic	Other
Physician-owned heart hospitals	11	23,526	92.1%	3.6%	1.7%	2.6%
All local competitors	79	363,960	85.2%	9.6%	2.2%	3.1%
Not-for-profit	52	272,663	86.1%	9.3%	1.7%	2.9%
Proprietary	20	67,463	87.2%	7.6%	2.5%	2.7%
Government	7	23,834	69.3%	17.8%	6.8%	6.1%

Note: Local competitors are located in the same hospital referral region (as defined in the Dartmouth Atlas) as the physician-owned heart hospitals and performed a minimum volume of certain heart procedures.

Source: MedPAC analysis of discharge data for Medicare beneficiaries in the fiscal year 2002 MedPAR file from CMS.